

Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: TN3701	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 01/08/2014
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NAME OF PROVIDER OR SUPPLIER CHURCH HILL CARE & REHAB CTR	STREET ADDRESS, CITY, STATE, ZIP CODE 701 WEST MAIN BLVD CHURCH HILL, TN 37642
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 002	<p>1200-8-6 No Deficiencies</p> <p>During the Licensure survey and complaint investigation number 32977, conducted on January 6-9, 2014, at Church Hill Care & Rehab Center, no deficiencies were cited under chapter 1200-8-6, Standards for Nursing Homes.</p>	N 002		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Donna O. Davis

TITLE

Administrator

(X6) DATE

1/29/14